SLO County Drug & Alcohol Services Application for Services

Client Name	Date of Birth	Age	Gender
Street Address	City	State:	Zip
Mailing Address (if different than above)	City	State	Zip

Home Phone	Cell Phone	Work Phone	Email Address

Social Security No.	**Driver's License No.**	**Driver's License State**
Full name as it appears on your birth certificate		**Mother's FIRST name**

BIRTHPLACE	IF CALIF. which COUNTY?	If NOT CALIF. which STATE?	If NOT USA which COUNTRY?

CHILDREN	**Are you pregnant? Yes ☐ No ☐** **Due Date:**	***Number of children 0 - 5 years**	**Number of children 6 - 17 years**
	Names and Ages of children under 18		

Are the children in your care/custody? Yes ☐ No ☐ **Which children are not in your care, if any?**	**Are they in the care of a relative or in foster care? Yes ☐ No ☐** **Have you had or do you have an open CWS case? Yes ☐ No ☐**

PRIMARY LANGUAGE	English ☐	Spanish ☐	☐ Other (specify)
MARITAL STATUS	Never married ☐	Married ☐	Widowed ☐ Divorced ☐ Separated ☐

ETHNICITY *choose up to 5*	White ☐	American Indian ☐	Korean ☐	Hawaiian ☐	Other Asian ☐	Alaskan Native ☐		
	Hispanic ☐	Japanese ☐	Filipino ☐	Vietnamese ☐	Laotian ☐	Asian Indian ☐		
	Black ☐	Chinese ☐	Samoan ☐	Guamanian ☐	Cambodian ☐	Mixed Race ☐	Other Race ☐	

SCHOOL	High School ☐ College ☐ Highest Year Completed	Current School Name
MILITARY	Are you a Veteran? Yes ☐ No☐ Have Veteran Benefits? Yes ☐ No☐	
WORK	Employed full-time ☐ (35 hours or more) Part time ☐ (Less than 35 hrs) Unemployed ☐ (Looking for work) Unemployed ☐ (Not looking for work) Not in the labor force ☐ (Not seeking work)	

INCOME	Do you have Medi-Cal? Yes ☐ No☐	Are you a CalWorks Participant? Yes ☐ No☐	Your approximate monthly income? $	Number of Days you were paid for working in the last 30 days?
DISABILITY Can choose more than 1	None ☐ Visual☐ Hearing ☐ Speech ☐ Mobility ☐ Mental ☐ Developmentally Disabled☐ Other (not drug or alcohol) ☐			
EMERGENCY INFORMATION	Person to notify in case of an emergency Name Phone Number:		Relationship to you	
REFERRAL INFO	Referred by (Court/Agency/Person)	Have you been seen by us before? Yes☐ No☐ How long ago?_____		
LEGAL	Probation Officer Name	Court Case #	CDC #	Parole Officer Name

SERVICE AUTHORIZATION: I, the undersigned, am agreeing to drug and alcohols services and give my consent to the staff of San Luis Obispo County Drug and Alcohol Services to administer such screening, assessment, and services as considered therapeutically necessary and/or desirable. All procedures, including observed urinalysis for drug of abuse, patching, and breathalyzer, are to be discussed with me and I am free to decline or withdraw from services at any time. I expect to receive quality, professional care and understand that there is no guarantee that desired results will be obtained. I will be given recommendations, which may include referral to other services including: residential placement, detoxification services, employment and educational services, and other services as deemed necessary.

I understand that San Luis Obispo County Drug and Alcohol Services will maintain a record of my service contacts as required by law. Law protects the confidentiality of these records and no information that might identify me will be released without my specific written consent. Exceptions to this confidentiality are: medical emergencies, a judge's order to release information to a court, unreported abuses of a child, dependent adult or elder, or in the event that I am of danger to myself or others.

Client Signature_____ **Date**_____

Witness/Parent, when needed_____**Date**_____**Client Number**_____

SLO County Drug & Alcohol Services Health Questionnaire

Acuity Check List

Yes	No	
☐	☐	**Do you have current, severe and/or untreated health problems?**
☐	☐	**Do you feel that you are at risk for hurting yourself or someone else?**
☐	☐	**Are you being hurt by someone else or at risk of being hurt?**
☐	☐	**Are you currently under the influence of alcohol and or drugs (including narcotic prescriptions)?**

General Health Information

1. Date you last saw a doctor?	2. What was the purpose of the visit?	3. Date of your last physical?

✱**4.** Med-2 **How many times have you visited an Emergency Room in the past 30 days?** _____

✱**5.** Med-3 **How many days in past 30 have you stayed overnight in a hospital for physical health problems?**_____

✱**6.** **Med-4** **How many days in the past 30 have you experienced physical health problems?**_____

7. Ever had surgery? ☐Yes ☐No If Yes, for what:

8. Head injury that resulted in loss of consciousness? ☐Yes ☐No Date of injury:
If Yes give Details:

9. History of any other illness that may require frequent medical attention? ☐Yes ☐No Give Details:

10. **Are there any health concerns you currently have?** _____

✱11. **Med-5** **Are you pregnant?** ☐Yes ☐No	What is your due date?	Date of last menstruation?	Date of last GYN exam?

12. Allergic to anything? ☐Yes ☐No If Yes, what?

13a. List **ANY medications** you are currently taking: **INCLUDE-*psychiatric medications***, *Vitamins*, and *over-the-counter medications* such as Ibuprophen, Tylenol, Aspirin, Tums, Pepto Bismol, etc.

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-
-

13b Who is the prescribing doctor(s)?:_____

✱**14.** **Med-7** **Were medications prescribed by Drug and Alcohol Services as a part of your treatment?** ☐**Yes** ☐**No**

Communicable Diseases

15a. Have you ever been tested for TB? ☐Yes ☐No Date of last TB Test or last chest X-ray:_____

✱**15b.** **Med-8** **Have you ever had a positive TB Test?** ☐Yes ☐No

✱**16.** **Med-9** **Have you been diagnosed with Hepatitis C?** ☐**Yes** ☐**No** **Date of last test:** _____
Have you been tested for any another liver disease ? ☐Yes ☐No Specify:_____

✱**17.** **Med-10** **Have you been diagnosed with a Sexually Transmitted Disease?** ☐**Yes** ☐**No**
Did you get treated? ☐Yes ☐No Date of last test:

✱**18a.** **Med-11** **Have you been TESTED for HIV?** ☐Yes ☐No

✱**18b** **Med-12** **Did you receive results of the test?** ☐Yes ☐No Date of last HIV Test:

19. Have you EVER ☐ Injected drugs? ☐ Shared needles? ☐ Shared cottons? ☐Yes☐No *IF YES check all that apply.*

✱**20a.** **ADU 10-** **How many days in the past 30 have you injected drugs?** _____ **Last time injecting:** _____

20b. Have you EVER used the SLO County Needle Exchange? ☐Yes ☐No

Mental Health Questions

✱**21.** **MHD-1** **Have you ever been diagnosed with a mental illness?** ☐Yes ☐No Were you treated? ☐Yes ☐No
What type Treatment? ☐Outpatient ☐Inpatient

What was the diagnosis? _____

✱MHD-2 **How many times in the past 30 days have you received outpatient emergency services for mental health needs?**_____

✱MHD-3 **How many days in the past 30 days have you stayed 24 hours or more in a hospital or psychiatric facility for mental health needs?**_____

✱**MHD-4** **In the past 30 days, have you taken prescribed medication for mental health needs, *including medication for anxiety?***
☐**Yes** ☐**No** If Yes, please list on question **13a.**

22a. Past suicide attempts? ☐Yes ☐No How many attempts?_____
22b. Date of most recent attempt:

Client Name:	**Client Number:**

OVER

Medical Alcohol and Other Drugs

23. Are you in withdrawal today? ☐Yes ☐No If Yes, from what substance(s)?

24. Seizures, epilepsy, delirium tremens or convulsions? ☐Yes ☐No Date of last seizure:
If yes give details:

25. Do you have frequent blackouts? ☐Yes ☐No How frequently?

26. Are you currently smoking marijuana? ☐Yes ☐No Medical Marijuana Card? ☐Yes ☐No

Date last smoked

27. Have you ever overdosed? ☐Yes ☐No If Yes on What?
When?

General Screening

28. Do you have excessive heartburn or abdominal pains? ☐Yes ☐No

29. Do you currently have: Asthma? ☐Yes ☐No
Emphysema? ☐Yes ☐No
Chronic bronchitis? ☐Yes ☐No

30. Do you have back pain? ☐Yes ☐No

31. Do you get dizzy or faint? ☐Yes ☐No

32. Have you had a stroke? ☐Yes ☐ No If yes give details:

33. Have you been diagnosed with diabetes? ☐Yes ☐No

34. Have you had heart attack/chest pain or any problem associated with the heart? ☐Yes ☐No Date: of Heart Attack:
Give details:

35. Do you have high blood pressure? ☐Yes ☐No Low blood pressure ☐Yes ☐No

36. Would you like a dental referral? ☐Yes ☐ No

37. Do you have bleeding problems? ☐Yes ☐No

The medical staff recommends you:
***receive a yearly physical exam that includes lab tests. Referral to Community Health Centers.**
***receive a TB test every year if at risk (been in jail, or other exposure)**.

To the best of my knowledge the above information is accurate and true:

Client Signature: **Date:**

*****Staff Only Below*****

As the Drug and Alcohol Services Medical Staff, I have reviewed this form and recommend the client:

☐Needs Medical Evaluation before entrance to program
☐HIV and or Hep C Test if at risk or for 6 month window
☐Pregnancy Test
☐Prenatal Care
☐Counseled on signs/symptoms of withdrawal ☐Referred for Detox_____
☐Other_____

Recommendations were provided to client:

☐ Discussed with client in person.
☐ Mailed to client (copy to chart).
☐ Given to specialist (counselor) to be discussed with client.

☐ **No additional referral needed at this time.**

Medical Staff Signature: **Date:**

Client Name: _____ **Client Number:** _____

Drug and Alcohol Services
San Luis Obispo County

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION:
CRIMINAL JUSTICE REFERRAL

Name of Client:_____DOB_____

I hereby consent to communication between San Luis Obispo County Drug and Alcohol Services and:

☐ Court ☐ Parole Department ☐ Probation
☐ DMV ☐ MHS Center For Change ☐ Attorney and District Attorney
☐ Residential facilities ☐ Alternative Treatment Providers Listed

Out of County Court/Probation (specify) _____

Other referring Agency (specify) _____

The purpose of and need for the disclosure is to inform the applicable criminal justice/treatment agency (ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, urinalysis/breathalyzer results, payment record, and treatment plan.

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from confinement, probation or parole, or other proceeding under which I was mandated into treatment.

It is okay to leave messages on my machine or service ☐Yes ☐No Your Phone #_____

☐ Family members listed below for phone messages, payment information and scheduling of appointments.

Name	Relationship to Client	Phone #

I understand that my alcohol and/or treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that recipients of this information may redisclose it only in connection with their official duties. I understand that generally San Luis Obispo County Drug and Alcohol Services may not condition my treatment on whether I sign a consent form, but in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Special terms regarding revocability of Criminal Justice Program releases

Although HIPAA requires that consents be revocable and does not have an exception when a patient is mandated into treatment through the criminal justice system, 42 C.F.R. Part 2 sets forth some special rules when a patient's participation in a treatment program is an official condition of probation or parole, sentence, dismissal of charges, release from imprisonment, or other disposition of any criminal proceeding. While a consent form (or court order) is still required before any disclosure can be made about a criminal justice system ("CJS") referral, the rules concerning duration and revocability of the consent are different.

Under the special rules of 42 C.F.R. Part 2, consent can be made irrevocable until a certain specified date or condition occurs, and the duration of the consent can be linked to the final disposition of the criminal proceeding. 42 C.F.R. § 2.35. This allows programs to provide information even after the client leaves treatment. If the client does not comply with treatment, the program can report the problem to the judge or prosecuting attorney or testify in a probation revocation hearing because there has been no final disposition of the criminal matter. A CJS consent allows programs to use the expiration condition provided in 42 C.F.R. Part 2: "when there is a substantial change in the patient's criminal justice system status." A substantial change in status occurs whenever the patient moves from one phase of the criminal justice system to the next. For example, if a client were on parole or probation, there would be a change in criminal justice system status when the parole or probation ends, either by successful completion or revocation. Thus the program could provide periodic reports to the parole or probation officer monitoring the client, and could even testify at a parole or probation revocation hearing, since no change in criminal justice status would occur until after the hearing.

Dated:_____ _____
Signature of Client

_____
Signature of parent, guardian or authorized representative
(if required)

CLIENT NAME:_____ **CLIENT NUMBER:**_____

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
DEBT COLLECTION

Name of client:_____DOB:_____

I authorize San Luis Obispo County Drug and Alcohol Services to disclose to:
The San Luis Obispo County Probation Department or other collection agency

And I authorize the Probation Department or other collection agency to redisclose to:
The courts, attorneys, the State Franchise Tax Board and any other person or entity as necessary to collect or facilitate collection of any fees owed for services provided to me by the San Luis Obispo County Department of Drug and Alcohol Services and associated collection charges.

The following information: any information that will facilitate collection of fees owed

The purpose of the disclosure authorized in this is to:
Facilitate collection of fees owed and associated collection charges, which includes, without limitation, pursuing collection through the State Franchise Tax Board or a court of law.

☐ Family members listed below for phone messages, payment information, and collections status.

Name	Relationship to Client	Phone

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:
Upon payment in full of all fees owed and associated collection charges.

I understand that generally San Luis Obispo County Drug and Alcohol Services may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Revocability of Release

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 C.F.R. Part 2 you have the right to revoke any release of information that you have previously signed giving San Luis Obispo Drug and Alcohol Services permission to release information to another agency, business, person, or organization. However, both HIPAA and 42 C.F.R. Part 2 provide that if a program has already made a disclosure prior to the revocation, the program has acted in reliance on the consent and is not required to try to retrieve the information it has already disclosed. 45 C.F.R. § 164.508(b)(5); 42 C.F.R. § 2.31(a)(8).

Dated:_____ _____
Signature of Client

_____
Signature of parent, guardian or authorized representative where required

CLIENT NAME:_____ **CLIENT NUMBER:**_____

STATE OF CALIFORNIA
DEPARTMENT OF MOTOR VEHICLES
A Public Service Agency

Participant's Certification of DUI Program Enrollment or Completion

(Instructions for completing this form are on the reverse side.)

PROGRAM PROVIDER NAME:	PROVIDER'S ADP LICENSE NUMBER
SAN LUIS OBISPO COUNTY DRUG & ALCOHOL SERVICES	40-001-01-120

PARTICIPANT NAME: (LAST FIRST MIDDLE)	DRIVER LICENSE NUMBER OR "X" NUMBER

PROGRAM TYPE

☐ Education Only (23140 CVC Conviction) ☐ First Offender Program ____ months

☐ Multiple Offender Program ____ 18 months ____ 30 months ____ 18 of 30 months (IID Restriction only)

ENROLLMENT DATE	DL 107 CERTIFICATE NUMBER	OR	**COMPLETION** DATE	DL 101 CERTIFICATE NUMBER

I certify under penalty of perjury under the laws of the State of California that I have enrolled in, or completed the program as indicated above.

DATE	PARTICIPANT'S SIGNATURE	TELEPHONE NUMBER
	✍	( )

DL 804 (REV. 1/2003) WWW

Instructions for Completing the Participant's Certification of DUI Program Enrollment or Completion (DL-804)

This form is to be used under the following circumstances:

- When a program participant has completed all the required DUI Program components, but you are unable to immediately issue a Notice of Completion Certificate (DL 101) and capture the participant's signature on the (paper) completion certificate.
- When a program participant has completed all the required DUI program components and you are submitting an electronic Notice of Completion Certificate (DL 101) via an authorized Internet access link with the Department of Motor Vehicles (DMV).
- When a program participant has enrolled in a DUI program and you are submitting an electronic Proof of Enrollment Certificate (DL 107) via an authorized Internet access link with the DMV.

This form captures the participant's signature, which certifies under penalty of perjury that the participant has either enrolled in a DUI program, or completed the required DUI program. This signature would normally be on the DL 101 or DL 107, but in the above circumstances you may not be able to capture the participant's signature on the certificate.

Please, ensure that the information on this form is consistent with the information on the Proof of Enrollment Certificate (DL 107) or the Notice of Completion Certificate (DL 101) you submit for the identified participant.

You must retain this form in your office in a manner that will allow you to retrieve it by searching for the serial number of the corresponding Certificate (DL 107 or DL 101) and for the period required by Section 9866 of Title 9, California Code of Regulations.

On the printed Notice of Completion Certificate (DL 101) you submit without a participant's signature, type or print the words "Signed DL 804 in file" in the space provided for participant's signature.

Do not submit a DL 804 to DMV unless you are requested to do so.

DL 804 (REV. 1/2003) WWW